Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

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State/Territory: North Carolina
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Nina_Yeager,_Director, Division of Medical Assistance
(Signature of Agency Head)

SCHIP Program Name(s): North Carolina Health Choice for Children

SCHIP Program Type:
____Medicaid SCHIP Expansion Only
_X__Separate SCHIP Program Only
_____Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: ___December 20, 2001___

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility --

North Carolina changed the eligibility standards for NC Health Choice for Children by establishing a waiting list for children who came to the program. The freeze for new enrollees went into effect on January 1, 2001 and ended October 8, 2001. During the course of the freeze 36,000 children were processed through the waiting list.

The state also chose to change the definition of uninsured by adding those children who meet this criteria. Health insurance benefits available to the family of a special needs child have been terminated due to a long-term disability or a substantial reduction in or limitation of lifetime medical benefits or benefit category.

B. Enrollment process--

The enrollment process was changed as follows: for those children who met special needs criteria and therefore could remain covered by private health insurance until enrollment in the program, eligibility workers determined the date private insurance was terminated and these children became eligible effective the first of the month following termination of private health insurance.

Under the new enrollment freeze, children who were found to be eligible for NC Health Choice were sent a notice informing them that North Carolina had insufficient funds to enroll them in the program. The children were placed on a waiting list on a first come, first served basis based on a number assigned statewide upon the receipt of the child's application. The waiting list offered the children's families the right to a letter asking them three questions--are you living at the same address, has your income changed since you were placed on the waiting list, and do you have health insurance. Children were taken off the waiting list in stages beginning with the oldest cases first. The first group of children (5,000) was taken off the list on July 2, another group the first week of August, then the first week of September and finally on the 5th of October. The total number of children who were processed through the waiting list was 35,916. Of these children approximately one-

half were still eligible for NC Health Choice, about one-third were eligible for Medicaid, about 10 percent found private health insurance, the remainder did not respond to efforts to contact them.

C. Presumptive eligibility **NC**

D. Continuous eligibility **NC**

E. Outreach/marketing campaigns -- **Outreach and marketing campaigns were changed as follows -- With the freeze in new enrollments, most outreach efforts were stepped down except for some investigative work on reenrollment, a new application form, and certain counties who wanted to continue the process.**

F. Eligibility determination process --**The process for determining eligibility for children with special needs changed to allow counties to query families about special needs criteria, to provide them with a form for a physician to sign and to enroll the child determined to be eligible the first day of the month following the dropping of insurance coverage.**

G. Eligibility redetermination process -- **During the course of the year focus groups were conducted to see what could be done to improve redetermination once money was available again through the state budget.**

H. Benefit structure **NC**

I. Cost-sharing policies **NC**

J. Crowd-out policies **NC**

K. Delivery system **NC**

L. Coordination with other programs (especially private insurance and Medicaid)-- **NC**

M. Screen and enroll process -- **NC**

N. Application -- **NC**

O. Other -- **NC**

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children. * <u>See discussion below for entire 1.2 response.</u>**

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

____ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

North Carolina was forced to freeze new enrollments in NC Health Choice for Children and start a waiting list from January 1, 2001 to October 8, 2001. The decision was based on these factors:

1) **The original state budget as well as the federal budget were based on the Current Population Survey of the US Census Bureau. The decision at the state level was to budget state funds for an annual average of 66,000 children. This was based on two concepts: that no program has ever enrolled 100% of its actual eligibles and that to use all the federal money prior to "the dip" would force us to actually drop children from the program during the dip years. The total numbers of children estimated to be eligible for the S-CHIP program was 71,343. This was based on the assumption that a little**

more than half of those below 200 percent were S-CHIP eligible rather than Medicaid eligible. Enrollment in the NCHC program, however, while showing no signs of a slowing rate, reached 72,000 at its lowest point in December, 2001. In fact, in December, 2001, the program briefly reached a high of 77,000. Medicaid enrollments also increased during this time period. By the end of the freeze period 90 percent of the waiting list children were on NC Health Choice, Medicaid or private insurance.

2) **Despite the fact that some additional federal funds were made available to the state, the North Carolina General Assembly in its 1998 budget session included language prohibiting the transfer of any additional state funds not appropriated by the General Assembly into the NC Health Choice for Children program.**
3) **In fact, the waiting list was comprised primarily of Medicaid graduates. 36,000 children were processed through the waiting list during the freeze, while the lowest point in enrollment reached 51,000 during the freeze. Clearly there are far more children eligible for the program than estimates would indicate. Because NC Health Choice is non-entitlement, any profound underestimates of numbers of eligible children will force the state to freeze the program again. Under North Carolina law, benefits cannot be reduced without an act of the NC General Assembly. The General Assembly has also kept its language prohibiting administrative transfer of funds to prohibit the freeze.**
4) **Frankly the negative publicity surrounding the freeze led to an improved reenrollment rate. Only 25% of our families failed to reenroll when eligible because of the reality facing them of not being able to reclaim their health insurance.**
5) **The freeze was lifted because the General Assembly appropriated funds to cover additional children over the next two years. The legislature approved a tax increase to make up for a profound budget shortfall, but NC Health Choice for Children became one of very few programs to receive an expansion budget request rather than a budget reduction. Because of careful budget planning and restrictions on drawing down additional federal funds, NC is likely to be able to get through at least the first year of "the dip" without having to remove children from the program. The primary goal of the state has been to keep its word to enrolled children and not reduce benefits or remove active enrollees from the program except by the recipient's action or inaction.**
6) **It is clear to the state that the estimates of numbers of uninsured children need to be modified. We have no clear way to do it because of our profoundly negative experience with CPS numbers. We know they are wrong, yet they represent the only sanctioned instrument to provide a state to state numbers comparison. This is also the instrument cited in federal law on which we are told the federal government will base our numbers.**
7) **As to the impact of the freeze on outreach and enrollment in Medicaid, the answer is somewhat complicated. Active outreach for all intents and purposes was halted after January 1, 2001 because of the freeze, although a lower level of activity did continue. Meanwhile, the state of North Carolina was undergoing a severe economic downturn – one of the first states to be adversely affected by the national downturn. While the children's Medicaid program called Medicaid Infants and Children (MIC), the equivalent of SOBRA showed a 4.6 increase from October 2000 to October 2001, the TANF program which more closely parallels economic downturns showed a 19% increase in the same time period. That is to say more children were enrolled in Medicaid, but more came in out of dire economic necessity than out of outreach efforts.**

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

NOTE: The overriding problem of the NC Health Choice freeze impacted all aspects of the program. We do plan to change our performance goals and objectives. That is difficult to accomplish when enrollments are frozen. We did more closely examine how we were doing with access issues for those already enrolled. Both the attached Sheps Center Report and UNC-Charlotte reports reflect this information Generally, the level of satisfaction of parents of children in this program is very high, parents report increased access, less absenteeism from school, etc.
Note: One of our objectives regarding service delivery had to do with appropriate immunizations. This report will be forwarded at a later date.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
		Data Sources: Methodology:

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Progress Summary:
Objectives Related to SCHIP Enrollment		
		Data Sources: Methodology: Progress Summary:
Objectives Related to Increasing Medicaid Enrollment		
		Data Sources: Methodology: Progress Summary:
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
		Data Sources: Methodology: Progress Summary:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
		Data Sources: Methodology: Progress Summary:
Other Objectives		
		Data Sources: Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Assessing the effects of the North Carolina Health Choice Program on Beneficiary Access to Care, Rebecca T. Slifkin, Ph.D, Victoria Freeman, R.N. Dr. PH., Pam Silberman, J.D., Dr. P.H., Robert Schwartz, M.A. Cecil G. Sheps Center for Health Services Research, September 25, 2001

University of North Carolina Charlotte, Policy Report No. 9, Statewide Assessment of Patient Experience in North Carolina Health Programs for Low-Income Populations: Evaluation of NC Health Choice for Childrenby William P. Brandon, PhD, MPH, Nancy Schoeps, PhD, Betsy J. Walsh, JD, MPH, and Laure D. Shull, MS University of North Carolina Charlotte June 6, 2001

Utilization and Risk Assessment for the North Carolina Health Choice Program October 1, 1998 to September 30, 2001, A Corporate Analysis and Risk Assessment by Blue Cross, Blue Shield of North Carolina

Average months federal fiscal year 2001

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out**. N/A**

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults
_____Number of children

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s**). N/A**

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

_____Number of adults
_____Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program? **The intentional dropping of affordable health insurance for the purpose of creating eligibility into the program.**

B. How do you monitor and measure whether crowd-out is occurring? **Through family surveys and through cross-matches with BCBS records.**

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation. **Please see Cecil G. Sheps Center Report**

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program?

Describe the data source and method used to derive this information. **It is our experience that there is little affordable health insurance available for dependent coverage below 200 percent of poverty. And as health insurance premiums rise, we are seeing more and more of a decline in both employers offering dependent care and in private policies offering affordable care. We have had a two-pronged anti-crowd out approach --- a two month period of uninsurance before a child was determined eligible for NC Health Choice. This became extremely onerous during the freeze as children had to meet this standard to get on the waiting list. An amendment is now pending to remove this provision and to electronically track the number of children who drop health insurance to prevent dual insurance coverage. The other tactic that was used was the imposition of an enrollment fee of $50 for one child or $100 for two or more children for families whose incomes are over 150% of poverty. Although only 30 percent of the families in NC Health Choice earn above 150% of poverty, prior to the freeze failure to pay the enrollment fee was the leading reason for denial into the program. In some cases county based foundations appear to be making scholarships available to these families.**

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness? A survey by the Cecil G. Sheps Center for Health Services Research asked respondents how they heard about NC Health Choice. The most common response was Department of Social Services (62%). In addition, 25% of respondents learned about the program from the health department, 9% from another health care provider, 9% from their child's school or child care, 9% from the media, 9% from posters or billboards, and 7% from friends and coworkers. (Respondents could mention more than one source of information, so percents add to more than 100).

North Carolina has done well with SCHIP outreach because the major thrust was a local grassroots outreach coalition strategy. Local coalitions were asked to pull in an ethnically diverse group of individuals representing public and private NFP agencies, churches, businesses, schools/child cares, providers, media, and consumers such that a broad-based, multifaceted, and ethnically targeted local planning and implementation process would result. The State's role then became one of supporting local coalition efforts by providing the tools: print materials, electronic media, programmatic and data updates, consultation / technical assistance, workshops, outreach to state and regional organizations, newspaper coverage, newsletter articles, etc.

By the end of FFY 1999-2000, we were approaching our program's capacity (based on a capped State budget) and we were faced with the likelihood of a freeze on new enrollment. By the end of December 2000, we had enrolled 72,000+ children although the original projection of children eligible for this program was 71,343. A freeze on new enrollment went into effect January 1, 2001 and continued through June. We began reactivating enrollment for children on the waiting list in July, and with passage of a new State budget in late September, open enrollment became possible effective October 8th.

Some outreach activities pursued by the State in the Fall of 2000, prior to the freeze, included:

- Work with the NC Hotel and Motel Association who adopted Health Check / NC Health Choice Outreach as their volunteer effort as a part of Colin Powell's America's Promise. Also worked with the NC Restaurant Association. Both initially set a goal to do active outreach directed toward employees & their families.
- Work with the Medical Student Section of the NC Medical Society who adopted Health Check / NC Health Choice Outreach as their special project. They targeted families attending the NC State Fair and the four communities where our states' medical schools exist.
- Work with Communities-in-Schools Americorps Volunteers who were mentoring students and working with their families.
- Work with the March of Dimes and K-Mart Stores for a targeted outreach effort in October 2000 on National Make a Difference Day.
- Work with Wal-Mart on a targeted outreach effort through their pharmacies.
- Assured that each of these efforts linked with the outreach coalitions in their local communities.
- Information regarding the freeze and guidance to local coalitions to assist them in refocusing their outreach activities was disseminated.

Once the freeze on enrollment was in effect (January 2001), the State:

- Developed various materials (letters/forms) to explain the freeze and waiting list to families, and to prepare for notification of families on the waiting list when the program reopened. All materials are now disseminated in English (one side) and Spanish (other side).
- Refocused on local Covering Kids grant-funded demonstration projects to further work in several areas:
  - Institutionalization of outreach through schools & child care

centers.

- Efforts to improve the re-enrollment process.
- Development of additional provider "Q & A Tools".
- Application form revisions.

C **Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?**

According to the Sheps Survey, Hispanic/Latino children were much more likely to be reached through the public health department compared to other children (58% compared to 24% of whites and 21% of blacks). They were also much less likely to hear about NC Health Choice from the Department of Social Services (38% of Hispanic/Latinos, compared to 62% of whites and 68% of blacks).

Through our Duke Endowment Health Choice Minority Outreach Grant, we targeted outreach to African American, Hispanic/Latino and American Indian communities. From those projects, we learned that outreach is most successfully accomplished when the message is delivered personally from someone they trust. The different projects have utilized door to door canvassing, home visiting, and outreach to community agencies, organizations, health care providers, businesses, media and churches that specifically serve the population being targeted. The Covering Kids Projects have also identified the above *lessons learned* from targeting minority and immigrant populations in their counties.

Outreach and enrollment materials must be translated into Spanish and interpreter services must be made available at critical sites where enrollment occurs and where health care services are provided. Toward that end, a Latino Work Group has worked with the state to identify Spanish-speaking contacts at the county-level to whom the NC Family Health Resource Line may refer Spanish-speaking callers who wish to enroll their children. The Line also maintains a database of free and/or reduced price clinics to whom they may refer immigrant families who do not qualify for Health Check / Health Choice due to the five-year waiting period.

The Sheps Survey also revealed that rural residents were more likely than urban residents to report hearing about the program from another health care provider (13% versus 6%) and from billboards (12% versus 6%).

For children living in rural areas, having local grassroots outreach coalitions was a key factor to our success. Outreach efforts were intense, multi-faceted and tailored to the communities. Some of our most rural counties in North Carolina experienced early success in enrolling children and most achieved (or exceeded) their target goal of enrolling all of their *projected* potentially eligible population.

We now know that our CPS data undercounted our potentially eligible population.

C Which methods best reached which populations? How have you measured effectiveness?

See above

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

State/Local Re-enrollment Process:

- The State mails re-enrollment forms to the families of Health Check and NC Health Choice children two months prior to the end date of their coverage year so the family does not have to go to the department of social services for a redetermination.
- Approximately 3 weeks after the re-enrollment form is mailed to the family, a postcard is sent. This postcard reminds the family to return the form.
- If the re-enrollment form is not returned by the 25th day of the 11th month, a "timely notice" (state-developed form) is sent by the local department of social services to the family advising them that they risk losing benefits unless the form is returned within 10 work days.
- Finally, four work days prior to the end of the 12th month, the State mails a "termination notice" if re-enrollment has not occurred.
- Families are still given a 10 day "grace period" for accepting late re-enrollments (which is the first 10 calendar days of the month following the end of the enrollment period).

Additional Outreach Activities Associated with Re-enrollment:

- The State emphasizes the importance of re-enrollment and *personal* outreach in communicating with local coalitions. Re-enrollment messages have also been plugged into State-sponsored television and radio public service announcements.
- At the county-level, agencies are pursuing the following strategies beyond the state-required process:
  - Discussing the annual re-enrollment process at the time of enrollment.
  - Sending additional, personalized letters and postcards.
  - Deputizing volunteers and/or other community agency staff to do personal follow-up with families due to re-enroll (after signing a "Confidential Information Agreement").
  - Utilizing department of social services staff to do personal follow-up.
  - And trying a variety of other creative strategies including: autodialers; local media coverage; utilizing community service agencies and health care providers to remind families to re-enroll; encouraging outstationed workers to assist families with completion of re-enrollment forms; asking employers to assist with the re-

enrollment process by providing documentation of income; utilizing local Health Check Coordinators (outreach workers) to encourage families to re-enroll; or hiring part-time staff to assist with re-enrollment.

- Since North Carolina is a county-administered system, many counties have worked out agreements with the school systems to encourage enrollment and re-enrollment in the program at the beginning of the school year (utilizing "Back to School" outreach efforts). This coincides with the initial start up of the program that began in October. School-based health centers have particularly focused on this approach.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__X__ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
__N/a__ Targeted mailing to selected populations, specify population
__X__ Information campaigns
__X__ Simplification of re-enrollment process, please describe
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
__X__ Other, please explain (See section 2.5 A and information below

In FFY 2000-2001, North Carolina through their covering Kids Project, conducted a series of focus groups to better understand participants' perceptions, attitudes and beliefs about Health Check and NC Health Choice and the factors important to their re-enrollment decisions. Additionally, the groups provided feedback on drafts of new re-enrollment materials and on re-enrollment processes. A report was published and disseminated to state policymakers.

Subsequent to the publication of this report, a State Re-enrollment Work Group was convened to follow through on recommendations from the focus groups and to develop a State Work Plan for Re-enrollment. In the first few months, the group has developed a plan for refinement of the reenrollment process and is already implementing various aspects of that plan (including graphically designed pieces and more family-friendly notices, with all materials printed in English and in Spanish). In addition, other strategies to improve re—enrollment have been developed into a work plan and work is beginning to achieve those objectives.

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes, the same measures are being used in Health Check (Medicaid). Outreach for Health Check/NC Health Choice is seamless as the programs are marketed together, and the enrollment and re-enrollment processes are identical.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Although North Carolina does not have survey information that informs us regarding the most effective re-enrollment strategies from a statistically-significant perspective), the focus group report is helpful to our understanding of how the process can be improved.

Current measures that are contributing to our re-enrollment success to date include:

- **Mail-In Re-enrollment Form—mailed in envelope with logo. A re-enrollment message is being added to the outside of the envelope.**
- **Post Card—the look, timing and messages are being revised to reflect focus group input.**
- **Personal Follow-Up== focus groups recommend combination of friendly, clear/concise, graphically-designed notices and personal follow up or use of autodialer.**

One of the Covering Kids Pilots demonstrated the efficacy of a personal, family-friendly follow up "Urgent Letter" sent with a new re-enrollment application. Results of this effort over 6 months demonstrated that 25% of those receiving this reminder used that application to re-enroll.

Ironically, the freeze on new enrollment in NC Health Choice also contributed to our re-enrollment success. Letters were mailed to the families of all Health Choice enrolled children notifying them of the upcoming freeze on new enrollment and the importance of timely re-enrollment so that their children would not lose coverage for an indefinite period of time.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information. **Of the 15,093 on the waiting list whose applications were denied, approximately 7% did not reenroll because they had private health insurance, 24% had Medicaid and 26% did not respond. We asked them as part of the process of getting off the waiting list. This is consistent with previously conducted surveys. Please see the Cecil Sheps Center report pages 32-33.**

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? **Yes.** Please explain. **The application for both is the same; families are asked to provide pay stubs, everything else is self-verification subject to a look-back. No interview is required.**

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. **At the point of redetermination a child is placed in either Medicaid or S-CHIP depending on family income. We have attempted to make the process seamless.**

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? **No.** Please explain**. Medicaid is offered through a PCCM system in all 100 counties. In Mecklenburg County, families could also opt for HMO plans. In all 100 counties, S-CHIP is offered on an any-willing-provider, fee-for-service basis.**

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found? **Yes, prior to the freeze, the failure to pay the enrollment fee was the leading cause of denial (only those over 150% of the federal poverty level are subject to this fee). In the early days of the program 70% of the children on NCHC were from families below 150% of the federal poverty level. Once that became known, several counties were approached or approached local foundations which decided to pay the enrollment fee. Before the freeze, the ratio of below 150% to above 150% had changed to 65% to 35%. The differential between these two groups on utilization of such high cost services as emergency rooms slightly lowered the per member per month cost with this shift.**

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found? **No, because of the nominal fee, we have not studied it. The $20 emergency room out-of-pocket cost, however, appears to be less effective than was first thought. Current emergency room use seems to be rising among those over 150% fpl and is higher for all SCHIP children than for the dependent children members of the State Health Plan**

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results. **In general parents are very satisfied with the care available to them under SCHIP. Although they do report some problems seeing dentists, those families with children in SCHIP report that as a result of their health insurance their children are healthier, have fewer absences from school especially in preschool and primary years and are better able to participate in sports and other**

after school activities. See attached studies from the University of North Carolina at Charlotte and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care? **In addition to the two academic studies listed above, we use and analyze utilization data from claims forms. See attached Blue Cross/Blue Shield Utilization Report. Because the type of immunization cannot be obtained from claims forms, we also cross match our SCHIP members with Public Health's immunization data bank.**

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available? **All previously contracted studies are now in. We will continue to monitor utilization rates for the next few years. Once the budget picture brightens, we will ask the General Assembly for permission to contract for more information.**

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

Please see the discussion of the freeze on new enrollments listed above. Our great success – we had enrolled at one point in December of 2000 77,000 children—was also our great barrier. We enrolled more children than we had funds to enroll. Therefore we had to freeze our program to new enrollments and allow membership to drop below the budgeted enrollment target for the following fiscal year (66,000) until a new state budget was adopted. Because this is an S-CHIP state, and not a Medicaid expansion or a combination state, when we run out of funds, for whatever reason, we cannot enroll more children. In this case, our state budget was based on CPS numbers and we did not have enough state money in our budget to enroll more children. There also exists in the state law a prohibition against transferring funds into the NC Health Choice for Children budget for the purpose of drawing down more federal funds than the approved state budget allows.

A. Eligibility

B. Outreach

C. Enrollment

D. Retention/disenrollment

E. Benefit structure

F. Cost-sharing

G. Delivery system

H. Coordination with other programs

I. Crowd-out

J. Other

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).* ***NOTE: Program was frozen for new enrollment from January 1,2001 to October 7, 2001.***

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care			
per member/per month rate @ average of # eligibles	$75,791.519.00	$124,646,505.55	$142,823,467.46
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs			
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	$8,046,548.75	$8,952,073.85	$9.015.991.40
10% Administrative Cost Ceiling	$8,421,279.79	$13,849,611.73	$15,869,274.16
Federal Share (multiplied by enhanced FMAP rate)	$61,813,806.61	$97,553,682.68	$110,873,172.86
State Share	$22,024,260.14	$36,044,896.72	$40,966,286.00
TOTAL PROGRAM COSTS	$83,838,066.75	$133,598,579.40	$151,839,458.86

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001. N/A

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__State appropriations
_____County/local funds
_____Employer contributions
__X__Foundation grants –outreach efforts, testing effective strategies (Duke Endowment -- $150,000 matched by Medicaid—targeting minority populations.)
_____Private donations (such as United Way, sponsorship)
_____Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures. No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		**North Carolina Health Choice for Children**
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__x__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__x__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff __x__Other *(specify)* Medicaid eligibility staff at the county level
Average length of stay on program	Specify months	Specify months 8.27 months
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __x__Yes
Has a mail-in application	_____No _____Yes	_____No __x__Yes
Can apply for program over phone	_____No _____Yes	__x__No _____Yes
Can apply for program over internet	_____No _____Yes	__x__No _____Yes
Requires face-to-face interview during initial application	_____No _____Yes	__x__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months What exemptions do you provide?	_____No __x__Yes, specify number of months 2 months What exemptions do you provide? No fault job loss, or insurance loss, Medicaid graduates, children with special needs, moved out of state. Plan amendment is pending to remove this provision for all applicants following the format established for Special Needs children.

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage regardless of income changes	_____No _____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	_____No __x__Yes, specify number of months 12 months Explain circumstances when a child would lose eligibility during the time period *if acquired private health insurance or if applied for and approved for means tested assistance (for example SSI, TANF)*
Imposes premiums or enrollment fees	_____No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____No __X__Yes, how much? Enrollment fee: $50 annually for one child; $100 for two or more children for those making above 150% fpl Who Can Pay? __X_ Employer _X__ Family __X_ Absent parent __X_ Private donations/sponsorship __X_ Other (specify) The source of this money has no legal restrictions
Imposes copayments or coinsurance	_____No _____Yes	_____No __X__Yes For families above 150% fpl $5 for provider visit, $6 per prescription drug; $20 for non-emergency emergency fee.
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No __x__ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed **VERY LIMITED -name and address only. Form must be completed and signed and returned with accompanying income verfication**.

5.2 Please explain how the redetermination process differs from the initial application process.

The state mails the family a redetermination form with the name and address filled in. The family must complete and return, including sending in one month's worth of pay stubs (as in the original application), and an enrollment fee if they are above 150% of poverty.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

__185__% of FPL for children under age ___1____
__133__% of FPL for children aged ___2-5_____
__100__% of FPL for children aged ___6-18_____

Medicaid SCHIP Expansion

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

__200__% of FPL for children aged __1_____
_200___% of FPL for children aged __2-5_____
_200___% of FPL for children aged___6-18_____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes __X__ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$90 standard work related expenses	$	$90 standard work related expenses
Self-employment expenses	$operational expenses plus $90 standard work	$	$same
Alimony payments Received	$amount received with no deduction	$	$same
Paid	$amount paid	$	$amount paid
Child support payments Received	$amount received minus $50	$	$same
Paid	$amount paid	$	$amount paid
Child care expenses	$$175 for each child 2 years old and older $200 for each child under 2	$	$same
Medical care expenses	$n/a	$	$n/a
Gifts	$n/a	$	$n/a
Other types of disregards/deductions (specify)	$income deemed to TANF case	$	$income deemed to TANF case

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

X___No ___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

_X___No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

_X___No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

X Yes _ __ No The eligibility for children with Special Needs changed on November 1, 2000. As of that date, a child with special needs as defined in our plan Amendment would be defined as uninsured under certain specific circumstances.

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage

B. Employer sponsored insurance buy-in

C. 1115 waiver

D. Eligibility including presumptive and continuous eligibility –We anticipate updating our application form to make it more family friendly based on focus groups and readability scoring. We expect to eliminate the two-month period of uninsurance as a prerequisite for eligibility because it has not been found to be useful. We also anticipate changing the methodology for counting the income of the self-employed to simplify it for families.

E. Outreach It will be reinvigorated targeting minority groups and school children. We will fine tune our outreach efforts based on past successes and failures.

F. Enrollment/redetermination process

G. Contracting

H. Other – The NC General Assembly has passed a law permitting families to drop health insurance coverage upon enrollment in the program ending the two month waiting period for non-insurance. The action was taken because (1) there was no evidence that the waiting period had an impact on crowd-out and (2) with the freeze that had to be imposed on new enrollments some children were forced to remain uninsured for as long as ten months during the eight month freeze. Although the state hopes never to have to freeze new enrollments again, this is a possibility that always exists. A plan amendment is pending.

The program was reopened for new enrollment on October 8, 2001 when the NC General Assembly passed its budget. The budget will allow the program to enroll an average of 83,000 children. We anticipate being able to revamp our outreach efforts and to develop contingency plans so that should the need ever again rise for another freeze, the state will have marshalled the information county-by-county to provide

at least some protection to a list of identified uninsured/uninsured children who meet the program criteria.